Transplant Benefits

We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO IN-NETWORK SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO OUT-OF-NETWORK BENEFITS UNDER THE CONTRACT.

Care or treatment by means of acupuncture except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

Broken Appointments.

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery,** except as otherwise stated in the Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in the Contract.

Care or treatment by means of **dose intensive chemotherapy,** except as otherwise stated in the Contract.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. except as otherwise stated in the Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of Your **family:** spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in the Contract, services or supplies related to **Hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Services or supplies related to **Hypnotism.**

Services or supplies necessary because the Member engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

With respect to Out-of-Network benefits, **Nicotine Dependence Treatment,** except as otherwise stated in the Preventive Care section of the Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in the Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in the Contract for food and food products for inherited metabolic diseases.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

With respect to In-Network services and supplies, any service provided without prior Referral by the Member's **Primary Care Physician** except as specified in the Contract.

With respect to Out-of-Network benefits, services related to **Private Duty Nursing** care, except as provided in the Home Health Care section of the Contract.

Services or supplies that are not furnished by an eligible **Provider.**

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to In-Network services and supplies provided in the event of a Medical Emergency, and with respect to all Out-of-Network benefits.

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

With respect to Out-of-Network benefits, except as stated in the Preventive Care section of the Contract, **Routine Examinations** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; or pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Member would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the Member is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Member is temporarily outside the United States for a period of 6 months or less; and

- Subject to Our Pre-Approval, full-time student status, provided the Member is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by Us are Non-Covered Services and Supplies and Non-Covered Charges.**

Services provided by a **Social Worker,** except as otherwise stated in the Contract.

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Member's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.
Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

IMPORTANT NOTICE ***APPLICABLE ONLY TO OUT-OF-NETWORK BENEFITS***

The Contract has utilization review features which are applicable to **Out-of-Network** benefits. Under these features, PHS reviews Hospital admissions and Surgery performed outside of a Practitioner's office. These features must be complied with if a Member:

a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Member does not comply with these utilization review features, he or she will not be eligible for full benefits under the Contract. See the **Utilization Review Features** section for details.

What We pay is subject to all of the terms of the Contract. Read the Contract carefully and keep it available when consulting a Practitioner.

If You have any questions after reading the Contract You should call the PHS Customer Service Department at the number shown on Your Identification Card.

We are not responsible for medical or other results arising directly or indirectly from the Member's participation in these Utilization Review Features.

OUT-OF-NETWORK UTILIZATION REVIEW FEATURES

Important Notice: If a Member does not comply with the Contract's utilization review features, he or she will not be eligible for full benefits under the Contract.

Compliance with the Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the Member being eligible for coverage under the Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Contract.

Definitions
"Hospital admission" means admission of a Member to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

We call a Hospital admission or Surgery "emergency" if, after an evaluation of the Member's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Member's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Contract is not payable under the Contract.

"Regular working day" means Monday through Friday from 9 a.m. to 5 p.m. Eastern Time, not including legal holidays.

REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Member does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Contract.

Notice of Hospital Admission Required

We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Member does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by PHS before they occur. The Member or the Member's Practitioner must notify PHS and request a pre-hospital review. PHS must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Member or his or her Practitioner must notify PHS and request a pre-hospital review at least 60 days before the expected date of delivery, or as soon as reasonably possible.

When PHS receives the notice and request, we evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

PHS notifies the Member's Practitioner by phone, of the outcome of their review.

If PHS authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Member's admission must be reviewed by PHS again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than 60 days elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

PHS must be notified of all emergency admission by phone. This must be done by the Member or the Member's Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When PHS is notified by phone, they require the following information:
a) the Member's name, social security number and date of birth;
b) the Member's group plan number;
c) the reason for the admission
d) the name and location of the Hospital

e) when the admission occurred; and
f) the name of the Member's Practitioner.

Continued Stay Review
The Member or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time PHS is notified of such admission.

The Member, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

PHS also has the right to initiate a continued stay review of any Hospital admission. And PHS may contact the Member's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

PHS notifies the Member's Practitioner by phone, of the outcome of the review. And PHS confirms the out come of the review in writing. The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance. We reduce what We pay for covered Hospital charges, by **50%** if:
a) the Member does not request a pre-hospital review; or
b) the Member does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) PHS's authorization becomes invalid and the Member does not obtain a new one; or
d) PHS does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, We reduce what We pay for covered Hospital charges by **50%**, if:
a) PHS is not notified of the admission at the times and in the manner described above;
b) the Member does not request a continued stay review; or
c) the Member does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Member stays in the Hospital longer than PHS authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet the Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Member does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Contract.

We require a Member to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Member does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The Member or his or her Practitioner, must request a pre-surgical review from PHS. PHS must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When PHS receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

PHS notifies the Member's Practitioner, by phone, of the outcome of the review. PHS also confirms the outcome of the review in writing.

Required Second Surgical Opinion
If PHS's review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Member must obtain a second surgical opinion in order to get full benefits under the Contract. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the Member may obtain a third opinion, although he or she is not required to do so.

PHS will give the Member a list of Practitioners in his or her area who will give a second opinion. The Member may get the second opinion from a Practitioner on the list, or from a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the Member's Practitioner; and
c) does not perform the Surgery if it is needed.

PHS gives second opinion forms to the Member. The Practitioner he or she chooses fills them out, and then returns them to PHS.

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of the Contract, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, We reduce what We pay for covered professional charges for Surgery by 50% if:
a) the Member does not request a pre-surgical review; or
b) PHS is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) PHS requires additional surgical opinions and the Member does not get those opinions before the Surgery is done
d) PHS does not confirm the need for Surgery.

Penalties cannot be used to meet the Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

APPEAL PROCEDURE

Member Appeal Procedure
PHS Health Plans provides two different appeal programs. One program deals exclusively with the PHS Health Plans medical necessity decisions. The second is a grievance program that deals with more general concerns.

Medical Necessity Appeal
If you disagree with a PHS Health Plans decision that a health care service is not medically necessary and appropriate, you or a provider acting on your behalf may request an appeal. A three-stage appeal process is available.

The Stage 1 appeal is an internal review of the initial decision(s) to deny a medical procedure, supply and/or admission. You or a provider will have up to 60 days to file a Stage 1 appeal. The 60-day period begins on the date of receipt of the PHS Health Plans initial notice of adverse determination. Stage 1 appeals can be initiated by telephone or in writing. If the case involves urgent or emergency care, a decision on the appeal will not take longer than 72 hours. All other cases will be decided within five business days. The appeal is informal and allows you or your representative to discuss your case with the Medical Director who made the initial decision.

When a Stage 1 appeal is completed, you or your provider designee will be informed of the decision. If there is an adverse determination, PHS Health Plans will provide you and/or your provider designee with written notification. The notification will include the basis for the decision and an explanation of how to proceed to a Stage 2 appeal.

The Stage 2 appeal is a formal review of all medical records and other pertinent information by a clinical appeal panel of physicians and/or health care professionals who were not involved in the Stage 1 appeal. A Stage 2 appeal must be initiated 60 days from the date that you and/or your provider received notification of its Stage 1 appeal decision. Stage 2 appeals may also be requested either by telephone or in writing, and will only be conducted upon receipt by PHS Health Plans of all pertinent

medical information. We will send you our acknowledgement of your request within 10 days of receipt of your letter. A clinical peer who is trained or practices in the specialty of the case at issue will be available to the panel. Upon request, you or your provider may appear before the panel. You or your provider may also request that the clinical peer participate in the panel's review of the case. If the case involves urgent or emergency care, the panel will conclude its Stage 2 appeal no later than 72 hours after receipt by PHS Health Plans of all pertinent information. All other cases will be concluded within 20 business days. When there is a reasonable cause for a delay that is beyond the control of PHS Health Plans, an extension of up to 20 business days is permitted. Notice of the delay and need for additional time must be made to you and/or your provider during the original 20-day period. If the panel decides to uphold the adverse determination, the written notice will include the basis for its decision. A notice upholding the adverse determination will also include specific instructions on how you or your provider may initiate a Stage 3 external appeal and any necessary forms.

A Stage 3 appeal may be requested if you, or your provider acting on your behalf, disagree with the PHS Health Plans Stage 2 appeal determination. The Stage 3 appeal is a review of all pertinent information by an external review organization designated by the New Jersey Department of Health and Senior Services.

External appeals are subject to a filing fee of $25 unless financial hardship is demonstrated through evidence of eligibility for the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI; or New Jersey Unemployment Assistance. If there is a determination of financial hardship, the fee shall be reduced to $2. You must request that PHS Health Plans facilitates an external appeal by telephone or in writing. Upon such request, you will be provided with an appeal form and a general release of medical records form. You must fill out and sign the forms and mail them, together with the $25 fee (or a $2 fee with evidence of financial hardship) to: Office of Managed Care, Division of Health Care Systems Analysis, P.O. Box 360, Trenton, NJ 08625-0360.

Grievance (Reconsideration) Process

If you disagree with a PHS Health Plans decision that is not based on medical necessity, you or someone you designate to represent you can use the PHS Health Plans grievance process to address your concern(s).

Your first step is to call the PHS Health Plans customer service toll-free number on your ID card. If after speaking with a representative you are still dissatisfied with the PHS Health Plans decision, you have the right to file a grievance (request for reconsideration). You have up to six months from the date of the event to file a grievance. A request for reconsideration can be made over the phone by calling the PHS Health Plans customer service number on your ID card, or by writing to: PHS Health Plans Customer Service Department, 3501 State Highway 66, Neptune, NJ 07754. All written grievances will be decided and reported to you within 30 days of receipt of your complaint at PHS Health Plans.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A Member may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by the Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange or provide with what another plan pays or provides. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance coverages; nor
f) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. For a Member or Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan. The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply

where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works
We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:
a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second. But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.
- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under the Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) the Contract;
b) PIP; or
c) OSAIC.

"Eligible Services or Expenses" means that of service or expense provided for treatment of an Injury which is covered under the Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under the Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

The Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case the Contract will be primary.

If there is a dispute as to which policy is primary, the Contract will pay benefits or provide services as if it were primary.

Services and Benefits the Contract will provide if it is primary to PIP or OSAIC. If the Contract is primary to PIP or OSAIC it will provide services and benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract will apply if:
a) the Member is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits the Contract will pay if it is secondary to PIP or OSAIC.
If the Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if the Contract had been primary.

Medicare
If the Out-of-Network benefits under the Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AMENDMENT

The Contract may be amended, at any time, without a Member's consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under the Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under the Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received. No change in the Contract is valid unless the change is shown in one of the following ways:

a) it is shown in an endorsement on it signed by one of Our officers.

b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of the Contract called **Conformity With Law,** it is shown in an amendment to it that is signed by one of Our officers.

c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.

d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Contractholder or Member of any of the Contractholder's or Member's interest, as appropriate, under the Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS

No clerical error by the Contractholder or by Us in keeping any records pertaining to Coverage under the Contract will reduce a Member's Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, or the amount of coverage, subject to the Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Contract, and in what amounts.

CONFORMITY WITH LAW
Any provision of the Contract which, on its Effective Date, is in conflict with the laws of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under the Contract.

CONTRACT INTERPRETATION
We shall administer Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

GOVERNING LAW
This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a Member covered under the Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OFFSET
We reserve the right, before paying Out-of-Network benefits to a Member, to use the amount of payment due to offset a Out-of-Network claims payment previously made in error.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in the Contract, its riders and attachments. We have no other liability.

In-Network Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries, affiliates, or appropriate employees or companies in administering the Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Member's application may not be used by Us to void his or her coverage under the Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a Member, or has been mailed to a Member for attachment to his or her Evidence of Coverage.

THE CONTRACT

No statement will void the coverage, or be used in defense of a claim under the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member or to the Member's beneficiary.

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION

The health benefits provided under the Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS APPLICABLE TO OUT-OF-NETWORK BENEFITS

A claimant's right to make a claim for any benefits provided by the Contract is governed as follows:

NOTICE OF LOSS

A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.

PROOF OF LOSS

Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 day of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Member's death will be paid as soon as We receive due proof of the death to one of the following:

a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. For covered services from an eligible Facility or Practitioner, We will Determine to pay either the Member or the Facility or the Practitioner. The Employee may not assign his or her right to take legal action under the Contract to such provider.

PHYSICAL EXAMS

We, at Our expense have the right to examine the Member. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under the Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of the Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a Member is eligible to continue his or her group health benefits under both the Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of the Contract:

If a Member elects to continue his or her group health benefits under both the Contract's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Member:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. You must contact Your Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b) the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under the Contract during a continuation provided by this section is not a qualified continuee.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:
a) You were not terminated due to gross misconduct; and
b) You are not entitled to Medicare.

The continuation:
a) may cover You and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If you die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Contract, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.
Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) Your legal divorce or legal separation from Your spouse; or
b) the loss of dependent eligibility, as defined in the Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue the Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.
Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, Us, if:
a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under the Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:

I. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
II. with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
A. the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
B. the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
III. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
IV. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
V. the date the Contract ends;
VI. the end of the period for which the last premium payment is made;
VII. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
VIII. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read the Contract's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. If You acquire one or more Dependents after the continued health coverage begins, You may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, You must elect to continue health coverage for Yourself.

What the Employer Must Do

At the time of termination of employment or reduction of work hours, the Employer must notify You, in writing, of:
a) Your right to continue the Contract's group health benefits;
b) the monthly premium You must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under the Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Contract on a regular basis. Any modifications made under the Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for You to continue.

When Continuation Ends
A Member's continued health coverage end on the first of the following;
a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the Member becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;
e) with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by the Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under the Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if You stop paying.
b) the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c) the date the Contract ends or is amended to end for the class of Employees to which You belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Contract.

FAMILY LEAVE OF ABSENCE

Important Notice: This section may not apply to an Employer's plan. You must contact Your Employer to find out if:

a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to You.

If An Employee's Group Health Coverage Ends
Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date You return to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which Your coverage would have ended had You not been on leave; or
d) the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS
If You die, any of Your Dependents who were covered under the Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of Your death; or
b) the date the Dependent is no longer eligible under the terms of the Contract.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health coverage for Your former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under the Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) if he or she permanently relocates outside the Service Area.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under the Contract ends.

After group health coverage under the Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under the Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under the Contract.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by the Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person. If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under the Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged or provided for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:
a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged or provided services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not provide benefits under this Contract or arrange or provide services and supplies to or on behalf of a Covered Person, to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered person received from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Contract will be the secondary health plan for Members who are eligible for Medicare.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Member may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A Member is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Member is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Member's Covered Service or Supply or Covered Charge first, ignoring what the Member's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to You or Your covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Member, other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a Member who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare

When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When the Contract is primary

When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan. A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a Member who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such Member is referred to as a "disabled Medicare eligible". This section does not apply to:
a) a Member who is eligible for Medicare by reason of age; or
b) a Member who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Member Becomes Eligible For Medicare

When a Member becomes eligible for Medicare by reason of disability, the Contract is the primary plan. Medicare is the secondary plan.

If a Member is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of benefits and Services** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a Member who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Member is referred to as a "ESRD Medicare eligible". This section does not apply to a Member who is eligible for Medicare by reason of disability.

When A Member Becomes Eligible For Medicare Due to ESRD

When a Member becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Member becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a Member is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of benefits and Services** section of the Contract.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS PROCEDURE FOR OUT-OF-NETWORK BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to Determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.

b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.

c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

Rider G5 – Open Access to Specialists (Page 1 of 4)

THE GUARDIAN & PHS HEALTHCARE SOLUTIONS
HMO - POS PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
CHARTER POINT OF SERVICE
EVIDENCE OF COVERAGE

Physicians Health Services of New Jersey, Inc. ("PHS") certifies that the Employee named on The Guardian & PHS Healthcare Solutions Member Identification Card is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown on The Guardian & PHS Healthcare Solutions Member Identification Card carrier sheet, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between PHS and the Contract Holder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

Physicians Health Services of New Jersey, Inc.

Barry Averill

By: Barry Averill
President

THE GUARDIAN & PHS HEALTHCARE SOLUTIONS

OPEN ACCESS TO SPECIALISTS RIDER
EVIDENCE OF COVERAGE

SMALL EMPLOYER HMO-POS PLAN

Rider G5 – Open Access to Specialists (Page 2 of 4)

1. This rider eliminates the requirement on the part of the Member to obtain a referral from his/her Primary Care Physician (PCP) prior to receiving services from a Specialist Doctor or Provider. Every Member, however, must choose a Primary Care Physician, or PHS will assign one to You. Also, You are encouraged to contact Your Participating Primary Care Physician when seeking preventive care services or when a medical condition arises.

With regard to **Referral,** this rider modifies the following Sections and Pages of the Small Employer HMO-POS Plan Evidence of Coverage:

Cover Page, PASSPORTPOINT OF SERVICE is replaced with **CHARTER POINT OF SERVICE**

INTRODUCTION
What is a Point of Service Plan? The second sentence is replaced with the following: Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either an ***in-network provider*** or those of an ***out-of-network provider.***
How does a person access in-network providers? The third sentence of the first paragraph isreplaced with the following: The PCP supervises, coordinates, arranges or provides care, as appropriate.
The second paragraph is replaced with the following: Except in case of a medical emergency, in-network services and supplies can **only** be provided by an ***in-network provider.***
Does the POS plan cover the same services and supplies whether a person uses in- network providers or out-of-network providers? The first sentence of the second paragraph is replaced with the following: Since in-network services and supplies must be provided by a Participating Provider, and ***in-network providers*** are familiar with in-network covered services and supplies, the list of in-network covered services and supplies in a POS plan does not generally include as much detail as the list of out-of-network covered charges.

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES
NOTE The first sentence of the first paragraph is deleted.

DEFINITIONS
PRIMARY CARE PHYSICIAN (PCP) is replaced with the following: A Participating Provider who is a doctor specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; and is responsible for maintaining continuity of patient care.
REFERRAL is replaced with the following: With respect to In-Network services or supplies, specific direction or instruction from a Participating Provider in conformance with Our policies and procedures that directs a Member to a Facility or Provider for health care.

MEMBER PROVISIONS: APPLICABLE TO IN-NETWORK SERVICES AND SUPPLIES
REFERRAL FORMS The second paragraph is deleted.
MEDICAL NECESSITY The fourth sentence is replaced with the following: We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Participating Provider or a provider referred in writing by a Participating Provider without notifying the Member that such benefit would not be covered under the Contract.

COVERED SERVICES AND SUPPLIES APPLICABLE TO IN-NETWORK SERVICES AND SUPPLIES
OUTPATIENT SERVICES
Paragraph (a) is replaced with the following: the following services are covered only at a Participating Provider's office selected by a Member, or elsewhere upon prior recommendation by a Participating Provider.
Item (a) 2 is replaced with the following: **Home visits** by a Participating Provider
Item (a) 6 is replaced with the following: **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a Participating Provider and approved in advance by Us.
Item (a) 9 is replaced with the following: **Durable Medical Equipment** when ordered by a Participating Provider and arranged through Us.
Item (a) 11 is replaced with the following: **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Participating Provider and approved in advance by Us.
SPECIALIST DOCTOR BENEFITS
Paragraph (b) is replaced with the following: Services are covered when rendered by a Participating Specialist Doctor at the Practitioner's office or any other Participating Facility or a Participating Hospital outpatient department during office or business hours.
INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS
Paragraph (c) The first clause of the first sentence is replaced with the following: The following Services are covered when hospitalized by a Participating Provider , only at Participating Hospitals and Participating Facilities (or at Non-Participating facilities upon prior written authorization by Us);
BENEFITS FOR SUBSTANCE ABUSE AND NON-BIOLOGICALLY BASED MENTAL ILLNESSES
Paragraph (d) is replaced with the following: The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center.
Item (d) 1 The second sentence is replaced with the following: Benefits include diagnosis, medical, psychiatric and psychological treatment and other medically necessary services by a Participating Provider for the abuse of or addiction to drugs and Non-Biologically Based Mental Illnesses. The fourth sentence is replaced with the following: Members are additionally eligible for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS OR ALCOHOL ABUSE
Paragraph (e) is replaced with the following: We cover treatment of Biologically-Based Mental Illness or Alcohol Abuse the same way we would for any other illness, if such treatment is prescribed by a Participating Provider. We do not pay for Custodial care, education or training.

COVERED SERVICES AND SUPPLIES APPLICABLE TO IN-NETWORK SERVICES AND SUPPLIES (continued)
OUTPATIENT SERVICES (continued)

THERAPY SERVICES
Paragraph (g) is replaced with the following: The following Services are covered when rendered by a Participating Provider.
Item (g)1 is replaced with the following: Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries. This benefit consists of treatment for a 60 day period per incident of Illness or Injury,
beginning with the first day of treatment, provided that a Participating Provider certifies in writing
that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.

HOME HEALTH SERVICES
Paragraph (h) is replaced with the following: The following services are covered when rendered by a Participating Provider including but not limited to a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us.
Item (h) 3 is replaced with the following: **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Participating Provider certifies that such services are essential for the effective treatment of a Member's medical condition.
Item (h) 5 is replaced with the following: **Hospice Care** if Members are terminally ill with life expectancy of six months or less, as certified by a Participating Provider. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.
DENTAL CARE AND TREATMENT
Paragraph (i) The first sentence is replaced with the following: The following services are covered when rendered by a Participating Practitioner.
TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ) Paragraph (j) The first sentence is replaced with the following: The following services are covered when rendered by a Participating Practitioner.
THERAPEUTIC MANIPULATION
Paragraph (k) The first sentence is replaced with the following: The following services are covered when rendered by a Participating Practitioner.

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES
- The following item is deleted: With respect to In-Network services and supplies, any service provided without prior Referral by the Member's **Primary Care Physician** except as specified in the Contract.

-- AND --

2. All other terms and conditions of the HMO-POS Plan Evidence of Coverage remain in effect.

THE GUARDIAN & PHS HEALTHCARE SOLUTIONS

NO HOSPITAL COPAYMENT RIDER
EVIDENCE OF COVERAGE

SMALL EMPLOYER HMO-POS PLAN

This rider modifies the following Sections of the Small Employer HMO-POS Plan Evidence of Coverage;

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES, Hospital Inpatient (IN-NETWORK)

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES, Mental or Nervous Conditions and Substance Abuse, Inpatient (IN-NETWORK)

Rider G6

The In-Network Inpatient copayment per the Evidence of Coverage is replaced with the following:

	IN-NETWORK
Hospital: Inpatient (unlimited days)	$0 Copayment/day; maximum/admission $0; maximum/cal. year $0
Mental or Nervous Conditions and Substance Abuse	**Inpatient:** $0 Copayment/day; maximum/admission $0; maximum/cal. year $0; Maximum 30 days/calendar year

All other terms and conditions of the Evidence of Coverage with respect to Inpatient coverage remain in effect.

THE GUARDIAN & PHS HEALTHCARE SOLUTIONS

PRESCRIPTION DRUG CARD/MAIL ORDER RIDER
EVIDENCE OF COVERAGE

SMALL EMPLOYER HMO-POS PLAN

1. This rider modifies the following Sections of the Small Employer HMO-POS Plan Evidence of Coverage:

   INTRODUCTION, "How much will it cost for services and supplies if a person uses in-network providers?"

   SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES, Prescription Drugs

Rider [G8]

The Prescription Drug coverage per the Evidence of Coverage is replaced with the following benefit:

In-Network:

For each prescription or refill which is **not** obtained through a Mail Order program:
$5 Copayment per prescription for Generic Drugs
$10 Copayment per prescription for Brand Name Drugs

For each prescription or refill which is obtained through a Mail Order program:
$0 Copayment per prescription for Generic Drugs
$5 Copayment per prescription for Brand Name Drugs

Out-of-Network Deductible/Coinsurance

2. This rider modifies the **DEFINITIONS** Section of the Small Employer HMO-POS Plan Evidence of Coverage by adding the following:

   Brand Name Drugs mean:
   a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are despensed; and
   b. protected by the trademark registration of the pharmacetuical company which produces them.

   Generic Drugs mean:
   a. therapeutically equivalent drugs, as determined by the Food and Drug Adminstration and as listed in the Formulary of the State in which they are dispensed;
   b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
   c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration

   Mail Order Program means a program under which a Member can obtain Prescription Drugs from a mail order pharmacy by ordering the drugs through the mail. Quantities ordered through a Mail Order Program are limited to a three month supply for Maintenance Drugs or a 34-day /100 dose supply of any other Prescription Drug.

3. All other terms and conditions of the Evidence of Coverage with respect to Inpatient coverage remain in effect.

THE GUARDIAN & PHS HEALTHCARE SOLUTIONS

$5,000 COINSURED CHARGE LIMIT RIDER
EVIDENCE OF COVERAGE

SMALL EMPLOYER HMO-POS PLAN

This rider modifies the following Sections of the Small Employer HMO-POS Plan Evidence of Coverage:

OVERVIEW OF THE PLAN, Coinsured Charge Limit

Rider [G9]

This rider reduces the Coinsured Charge Limit from $10,000 to $5,000. All other terms and conditions of the Evidence of Coverage with respect to the Coinsured Charge Limit remain in effect.

ZEV WACHTEL
121 STONEHURST DR
TENAFLY NJ 07670